Supreme Court, U.S.
FILED
DEC 16 1996

No. 96-578

In the Supreme Court of the United States

OCTOBER TERM, 1996

ALLEMNORE COMMUNITY HOSPITAL, INC., ET AL.,
PETITIONERS

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

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16 pp

QUESTION PRESENTED

Whether the Tucker Act, 28 U.S.C. 1491, provides for review of claims by providers of Medicare services when 42 U.S.C. 1395*oo* of the Medicare Act provides for administrative and judicial review of such claims.

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OPINIONS BELOW

The order of the court of appeals (Pet. App. 1-2) is unpublished, but the decision is noted at 92 F.3d 1206 (Table). The opinion of the United States Court of Federal Claims (Pet. App. 5-7, 9-10) is reported at 32 Fed. Cl. 608. The orders of the United States Court of Federal Claims (Pet. App. 11-12) are unreported.

JURISDICTION

The judgment of the court of appeals was entered on July 9, 1996. The petition for a writ of certiorari was filed on October 7, 1996. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Title XVIII of the Social Security Act establishes a federally funded health insurance program for the elderly and disabled known as Medicare. See 42 U.S.C. 1395 *et seq.* (the Medicare Act). The Secretary of Health and Human Services (the Secretary) has delegated administrative responsibility for the program to the administrator of the Health Care Financing Administration (HCFA). The Social Security Amendments of 1983 amended 42 U.S.C. 1395ww and replaced the "reasonable cost" system of reimbursing provider hospitals with a Prospective Payment System, under which payment rates generally are established without regard to a hospital's actual costs. See *Good Samaritan Hosp.* v. *Shalala*, 508 U.S. 402, 406 n.3 (1993).

Section 1395ww also provides for additional payments in "outlier" cases in which a patient's hospital stay is unusually lengthy or costly when compared to most discharges classified within the same discharge related group (DRG). 42 U.S.C. 1395ww(d)(5)(A). The Secretary is required to establish payment criteria applicable to all Medicare hospitals for outlier cases prior to each federal fiscal year. *Ibid.* The total amount of outlier payments made under Section 1395ww(d)(5)(A) for discharges in a fiscal year "may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year." 42 U.S.C. 1395ww(d)(5)(A)(iv). For each fiscal year since 1984, the Secretary has established prospective outlier payment criteria so

that nationwide outlier payments were expected to equal between five and six percent of total PPS inpatient services payments. See, *e.g.*, 48 Fed. Reg. 39,776-39,777 (1983); 49 Fed. Reg. 264-266 (1984).[1]

In January 1984, the Secretary stated that outlier criteria and payments for a fiscal year would not be adjusted retroactively based on actual annual Medicare payment data for that fiscal year:

> Using the data we had available, we set the outlier criteria so that an estimated six percent of total payments would be made for outliers. Nevertheless, there is no necessary connection between the amount of estimated outlier payments and the actual payments made to hospitals for cases that actually meet the outlier criteria. While we expect that under these criteria outlier payments will approximate six percent of total payments, we will pay for any outlier that meets the criteria, even if aggregate outlier payments result in more than six percent of total payments. Under such circumstances, we will continue to make these payments for the remainder of the Federal fiscal year without adjusting the DRG rates to compensate for the additional payments. Similarly, if we overestimate the amount of outlier payments, we will not adjust the DRG rates

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[1] To make outlier payments budget-neutral, Congress directed the Secretary to reduce PPS rates to reflect the percentage of expected outlays for outlier payments. 42 U.S.C. 1395ww(d)(2)(E) and (3)(B).

> to compensate hospitals for funds that were not actually paid for outlier cases.

49 Fed. Reg. 265 (1984). The Secretary reiterated that position in succeeding years.[2]

2. Section 205(h) of the Social Security Act, 42 U.S.C. 405(h), which is made applicable to the Medicare Act by 42 U.S.C. 1395ii, provides:

> The findings and decision of the [Secretary[3]] after a hearing shall be binding upon all individuals who were parties to such hearing. *No findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided.* No action against the United States, the [Secetary], or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this subchapter."

42 U.S.C. 405(h) (emphasis added).

The Medicare Act allows provider hospitals to challenge their payments under the Medicare program. Each fiscal year, hospitals submit to a fiscal intermediary a cost report containing the hospital's request for reimbursement. 42 U.S.C. 1395h; 42 C.F.R. 413.20. The fiscal intermediary audits the cost report and issues a Notice of Program Reimbursement

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[2] See 50 Fed. Reg. 35,708-35,710 (1985); 51 Fed. Reg. 31,523-31,525 (1986); 52 Fed. Reg. 33,047-33,049 (1987); 53 Fed. Reg. 38,504-38,510 (1988); 54 Fed. Reg. 36,498-36,500 (1989); 55 Fed. Reg. 36,075-36,077 (1990); 56 Fed. Reg. 43,227 (1991).

[3] Section 1395ii provides that the reference to the Commissioner of Social Security in Section 405(h) "shall be considered a reference to the Secretary * * * of Health and Human Services." 42 U.S.C. 1395ii.

(NPR) reflecting the total program reimbursement due the provider for items and services covered by the Medicare Act. 42 C.F.R. 405.1803, 405.1807, 413.60; see *Bethesda Hosp. Ass'n* v. *Bowen*, 485 U.S. 399, 401 (1988).

Under Section 1395*oo*, a provider that is "dissatisfied with a final determination of * * * its fiscal intermediary * * * as to the amount of total program reimbursement due the provider," or that is "dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection * * * (d) of section 1395ww," may request a hearing before the Provider Reimbursement Review Board (PRRB). 42 U.S.C. 1395*oo*(a)(1)(A)(i) and (ii).[4] The provider must request such a hearing within 180 days of the fiscal intermediary's final determination, and the amount in controversy must equal or exceed $10,000. 42 U.S.C. 1395*oo*(a)(2) and (3).[5] The Board may "affirm, modify, or reverse a final determination of the fiscal intermediary." 42 U.S.C. 1395*oo*(d). The Secretary further may either affirm, reverse, or modify the Board's decision. 42 U.S.C. 1395*oo*(f)(1). Following a final decision of the PRRB (or any reversal, affirmance, or modification by the Secretary), a provider may seek judicial review in the United States District Court in the judicial district where the provider is located or in the District of

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[4] Under the Act, certain determinations (not relevant here) are not reviewable. 42 U.S.C. 1395*oo*(g).

[5] For "good cause," the PRRB may waive the 180-day limitation for up to a three-year period. 42 C.F.R. 405.1841(b). The Secretary's regulations also allow for a hearing before the fiscal intermediary for amounts in controversy of at least $1,000 but less than $10,000. 42 C.F.R. 405.1809(a) and (b)(2).

Columbia. *Ibid.* Section 1395*oo* also provides for expedited judicial review in district court whenever the Board determines that it lacks authority over any "question of law or regulations relevant to the matters in controversy." *Ibid.*; see *Bethesda Hosp. Ass'n*, 485 U.S. at 401.

3. Petitioners are hospital providers which filed suit in the United States Court of Federal Claims to seek additional outlier payments for fiscal years 1985 and 1986 because the payments in those years allegedly "were less than the outlier payments due them under 42 U.S.C. § 1395ww(d)(5)(A)(iv)." Pet. 5. Petitioners contend that the court had jurisdiction over their claims under the Tucker Act, 28 U.S.C. 1491(a)(1).[6] Petitioners did not seek administrative or judicial review under Section 1395*oo* within 180 days after receipt of their NPR for the contested cost years, because, they allege, they were not aware until 1992 of the total amount of outlier payments nationwide in 1985 and 1986. Pet. 4-6.

The government moved to dismiss petitioners' respective complaints for lack of jurisdiction, claiming that the review procedures mandated by Section 1395*oo* preclude jurisdiction under the Tucker Act. During the pendency of the motion to dismiss, the Federal Circuit decided *St. Vincent's Medical Center* v. *United States*, 32 F.3d 548 (1994) (Pet. App. 13-23),

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[6] In relevant part, 28 U.S.C. 1491(a)(1) provides:

> The United States Court of Federal Claims shall have jurisdiction to render judgment upon any claim against the United States founded either upon the Constitution, or any Act of Congress or any regulation of an executive department, or upon any express or implied contract with the United States.

which held that "[b]ecause the Medicare Act contains its own comprehensive administrative and judicial review scheme, there is no Tucker Act jurisdiction over Medicare reimbursement claims." Pet. App. 16. Citing *St Vincent's*, the Court of Federal Claims granted the government's motions to dismiss petitioners' suits. *Id.* at 5-12. The cases were consolidated on appeal, and the Federal Circuit affirmed without opinion. *Id.* at 1-2.

ARGUMENT

The court of appeals' decision is correct and does not conflict with any decision of this Court or any other court of appeals. Further review is not warranted.

1. Section 205(h) of the Social Security Act, incorporated into the Medicare Act by 42 U.S.C. 1395ii, provides that "[n]o * * * decision of the [Secretary] shall be reviewed" by any "tribunal" except as provided by the Medicare Act. 42 U.S.C. 405(h). Because petitioners did not avail themselves of the administrative and judicial review procedures under Section 1395*oo*, the Federal Circuit correctly held that petitioners' claims must be dismissed.

Contrary to petitioners' suggestion (Pet. 8-12), construing Section 205(h) to limit judicial review here does not conflict with *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986). This Court held in *Michigan Academy* that 42 U.S.C. 405(h) and 1395ff(b)(1)(C) do not foreclose review in district court of the Secretary's Medicare Part B regulations establishing the method of determining benefits. 476 U.S. at 675, 680. The Court was guided by "the strong presumption that Congress intends judicial review of administrative action" and the ab-

sence of any explicit provision in Part B (as it then existed) for judicial review. *Id.* at 670. In the present case, however, petitioners seek under the Tucker Act review of agency action precisely contemplated by Section 1395*oo*, *i.e.*, the amounts of their reimbursements, including payments for outlier cases. Unlike in *Michigan Academy*, application of Section 205(h) to bar Tucker Act jurisdiction in the present case would not deny providers a means to obtain judicial review of their claims.

Prior to 1972, the Medicare Act did not permit hospital providers to challenge their Medicare cost determinations. S. Rep. No. 1230, 92d Cong., 2d Sess. 51 (1972). The Act was amended in 1972 and 1974 to establish the PRRB and provide a comprehensive scheme for review of payment disputes involving amounts of $10,000 or more. Social Security Amendments of 1972, Pub. L. No. 92-603, § 243(a), 86 Stat. 1420, 42 U.S.C. 1395*oo*; Act of Oct. 26, 1974, Pub. L. No. 93-484, § 3(a), 88 Stat. 1459, 42 U.S.C. 1395*oo*(f). Thus, the administrative and judicial review procedures of Section 1395*oo* are exclusive as to claims covered by Section 1395*oo*.

This Court has held that when Congress enacts a comprehensive administrative and judicial review scheme for challenging agency action, the Tucker Act does not provide an alternative basis for review. See *United States* v. *Fausto*, 484 U.S. 439, 448-449 (1988) (review procedures in the Civil Service Reform Act preclude judicial review under the Tucker Act); *United States* v. *Erika, Inc.*, 456 U.S. 201, 208 (1982) (Medicare Act's review provisions under Part B of the Medicare program preclude judicial review under the

Tucker Act).[7] Similarly, because Section 1395*oo* sets forth a precisely drawn and comprehensive scheme of judicial review of payments to providers under the Medicare program, the Tucker Act does not provide the Court of Federal Claims with jurisdiction to hear petitioners' claims.[8]

Petitioners do not dispute that their claims are covered by Section 1395*oo*'s review procedures. Pet.

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[7] This rule is consistent with the principle that a remedy furnished by a precisely drawn, detailed statute preempts a more general, otherwise applicable remedy. See, *e.g.*, *Brown* v. *General Services Admin.*, 425 U.S. 820 (1976) (Title VII of Civil Rights Act of 1964 preempts preexisting employment discrimination remedies); *Preiser* v. *Rodriguez*, 411 U.S. 475 (1973) (state prisoners may not seek redress under Civil Rights Act because of comprehensive remedial scheme of habeas corpus); *United States* v. *Demko*, 385 U.S. 149 (1966) (prison workers' compensation system preempts Federal Tort Claims Act); *Stonite Products Co.* v. *Melvin Lloyd Co.*, 315 U.S. 561 (1942) (specific venue statute for patent infringement cases is exclusive law governing venue in such cases).

[8] Petitioners mistakenly rely (Pet. 12-16) on cases disfavoring implied repeal of Tucker Act jurisdiction. See, *e.g.*, *Preseault* v. *Interstate Commerce Comm'n*, 494 U.S. 1 (1990); *Ruckelshaus* v. *Monsanto*, 467 U.S. 986 (1984). Those cases arose under the Just Compensation Clause and did not involve the present situation in which Congress specifically has provided for review of the purported claims in another forum. Similarly, petitioners' contention (Pet. 24) that there is no "'[c]lear and convincing evidence' of congressional intent to bar all judicial review" is erroneous in light of Section 1395*oo*. See also *Block* v. *Community Nutrition Inst.*, 467 U.S. 340, 350-351 (1984) ("This Court has * * * never applied the 'clear and convincing evidence' standard in the strict evidentiary sense," but "has found the standard met, and the presumption favoring judicial review overcome, whenever the congressional intent to preclude judicial review is 'fairly discernible in the statutory scheme.'" (citation omitted)).

4-6. Indeed, hundreds of Medicare providers have invoked Section 1395*oo* to challenge the level of their outlier reimbursement as not meeting the five percent projection required by Section 1395ww(d)(5)(A)(iv). See, *e.g.*, *Alvarado Community Hosp.* v. *Shalala*, No. CV 94-0972 (and consolidated cases) (C.D. Cal. May 3, 1996), appeal pending, No. 96-55967 (9th Cir., filed June 19, 1996). Petitioners' contention that they could not timely pursue review under Section 1395*oo* "through no fault of [their] own" (Pet. i), even if true,[9] does not create jurisdiction under the Tucker Act. Because Congress directed that providers dissatisfied with the program payments, including outlier payments computed under Section 1395ww(d)(5)(A), must first seek review before the PRRB, petitioners first must present their claims, including any arguments that would overcome the time limitations of Section 1395*oo*, to the PRRB. If the PRRB determines that petitioners are not entitled to relief for any reason, petitioners must seek judicial review of the PRRB's decision in district court. 42 U.S.C. 1395*oo*(f)(1).[10]

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[9] Petitioners argue (Pet. 4-5, 14) that, until 1992, they did not receive the Secretary's "final determination" of total aggregate outlier payments. However, the Secretary is not required to publish actual Medicare payment data on a nationwide basis, and the Secretary first set forth the prospective payment methodology for outlier payments in 1984. 49 Fed. Reg. 264-266 (1984). Thus, the absence of national data on total outlier payments did not prevent petitioners from making their own claims under Section 1395*oo*(a) within 180 days after receipt of their NPRs for any given cost year.

[10] The fact that petitioners may seek judicial consideration of their claims under Section 1395*oo* also belies petitioners' contention (Pet. 23-24) that to preclude Tucker Act jurisdiction over those same claims would raise constitutional questions.

2. Judicial review is also precluded because petitioners have not exhausted their administrative remedies before the PRRB. *Heckler* v. *Ringer*, 466 U.S. 602 (1984) (exhaustion of administrative remedies is mandatory in the Medicare program). Tucker Act jurisdiction would not relieve petitioners of their obligation to pursue administrative review before presenting their claims to the courts. See *Ruckelshaus* v. *Monsanto Co.*, 467 U.S. 986, 1018 (1984) (requiring exhaustion of administrative remedies before seeking relief under Tucker Act). Because petitioners failed to seek any review under Section 1395*oo*, the courts below properly dismissed their claims.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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DECEMBER 1996